HEALTH CARE QUALITY ASSURANCE AND UTILIZATION REVIEW FOR THE WISCONSIN MEDICAID PROGRAM

BIDDER'S QUESTIONS and ANSWERS
(Written Questions and Bidders' Conference Questions)

RFB #1603-DHCF-EG
Contract Period 07/01/2008-06/30/2009

Question: What is the anticipated retrospective review volume?

For the non-HMO inpatient and ambulatory surgical reviews, the expected volume would be 8,600 cases.

Question: It appears that the hierarchy will be used in addition to a random sampling methodology, is this correct? If so, what is the anticipated review volume for the random sampling of FFS claims and for the hierarchy reviews?

There is no random sampling for the Certificate of Need (CON) reviews. The CON reviews are 100% of the cases. Random sampling is used for the re-admissions and the short stays. From the total volume of these two types of admission, re-admissions have a higher selection priority than the short stays. It is expected volume would be 4,800 cases.

Question: CON-what is meant by this and how is it used in WI?

The Certificate of Need (CON) in Wisconsin complies with the federal requirement for review of inpatient hospital psychiatric services for individuals under the age of 21 years for medical necessity of the services. (42CFR 441.151 Subpart D – Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs)

The CON retrospective reviews are to determine whether the written documentation supports the medical necessity of the service, and whether these services are under the direction of a physician. (42CFR 441.152) The review also includes appropriate team certification for the services.

Question: Who is the state's current vendor(s) for UR and EQR?

The current vendor for utilization review of the Wisconsin Medicaid program fee-for-service (FFS) inpatient hospitalizations and ambulatory surgical services is MetaStar, Inc. MetaStar also does the external quality reviews for all cases reviewed in FFS and for the Medicaid program managed care and special managed care organizations.

Question: Has the State experienced any challenges, disappointment, etc. over the last contract period with the current vendor(s)? If so, please specify.

No

Question: Can the State provide the names of the organizations that submitted Bidder's Questions?

Question: Does the State have a budget for this contract?

Funding for this contract is contained within the Medicaid Contracts appropriation.

Question: Page 105, Appendix 1: Review Time and Cost Report. The number of reviews for SSI Abbreviated in section G is blank. Should this number be 5? In section 90.005, page 81, the second paragraph refers to the six SSI HMOs. As the Time and Cost Report includes a volume of one for the Comprehensive SSI review is it correct to assume that the other five should be included in section G as abbreviated?

The Review Time and Cost Report has been revised. Please refer to the amendments posted on the WEB site for the RFB, dated January 11, 2008. The number of SSI Abbreviated reviews was amended to 4.

Page 105, Appendix 1: Review Category G, Review Time and Cost Report, SSI Abbreviated is amended from 4 to 5.

Question: Page 106, Appendix 1: Review Time and Cost Report. The estimated Number of Cases for line J (Data Validity Audit) is listed as 12. We are assuming that this represents the number of HMOs. Can you supply us with the number of estimated claims or cases? If so, can we change the volume for this line to that number (# of cases) on the Review Time and Cost Report?

The Review Category J number of cases of 12 does represent the number of HMOs. It is expected that the number of cases for review may be 1000.

Question: Page 105, Appendix 1: Review Time and Cost Report, Review Category A, Referrals. The current number of cases for referral is 20. Will that number be enough to cover the referrals?

The number of cases was amended to 30 in Amendments posted on the WEB site for the RFB, dated January 11, 2008. The Department is revising that number from 30 to 40.

Question: Page 106, Appendix 1: Review Time and Cost Report, Review Category K, Pay for Performance, number of HMOs is 4. Is that an accurate count of the HMOs?

The Department is revising the number from 4 to 13.

Question: Does the Department use health care consultants to review and advise on clinical matters?

The Department does use health care professionals to review and advise on clinical matters. These activities and credentials are described in RFB #1603, Section 70.003, 70.700, 80.100, 80.200, 80.300, Appendix 3, Appendix 6, Appendix 10, Appendix 11 and with criteria identified in Appendix 9, and Appendix 12.